Eagle's Eye Workshop
Reservation and Registration Form

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(Version 2b dated 4/13/2026)

First name *

Last name *

Email *

Enter your email address

Phone *

Enter your phone number

We will only contact you by phone if we are unable to contact you via email

Workshop / seminar choice *

- ○ Private in-person session with Dr Roberts ($600)
- ○ Weekend workshop at Riverbend retreat center May 8-10, 2026 ($495)
- ○ Workshop at Riverbend Retreat Center May 8-10, 2026, if $100 deposit prepaid ($395)
- ○ Future July 2026 weekend workshop
- ○ Future September 2026 weekend workshop
- ○ Future November 2026 weekend workshop

(Exact dates for each future workshop will be specified once the registrations for the minimum number of attendees have been confirmed)

deposit choice

- ○ Deposit for the workshop specified above ($100)
- ○ Payment will be made in full

If the workshop you selected is full, you will be placed on a waiting list pending cancellations

☐ Check this box if you are willing to share a room at the retreat center. Please note that all rooms at the retreat center are double occupancy. If you are not willing to share a room please contact us for off- site hotels. *

Please provide the name of a person (if you have someone particular in mind) otherwise someone of the same gender will be assigned to your room.

Enter the full name of the person if you have a specific roommate in mind for the retreat center.

☐ Check if you will be staying offsite

Offsite hotel

If you will be staying offsite, please provide the name of the hotel. (Note that participants staying off-site will not be able to drive during the workshop - transportation to/from the workshop will be provided in this case)

Dietary preferences

Please list any special dietary restrictions or preferences

Accessibility issues

Describe any accessibility requirements or handicap issues or considerations

Current Medications, Supplements and Allergies

Medications *

List all medications, dosages and over-the-counter supplements - be specific with actual drug names

Ketamine Interactions

Enter "Yes or No if known. If yes please describe

Any meds known to have interactions with ketamine (e.g., antidepressants, antipsychotics, MAOIs, anti seizure meds): Yes / No If Yes, list:

Allergies *

Enter all medications, foods and environmental allergies

Substance use and Safety Screening

Alcohol use *

Enter "Yes" or "No". If "yes, please enter frequency / amount

Cannabis use *

Enter "Yes" or "No". If "yes, please enter frequency / amount

Other Substances *

Enter "Yes" or "No". If "yes, please enter frequency / amount

Include Opioids, stimulants, benzodiazepines, or other substances

Last Use Date

Month Day Year

approximate date of last use

History of Abuse *

Enter "Yes" or "No" . If "yes" please provide details

Psychiatric History

Have you ever been diagnosed with a mental health condition? (check all that apply):

Multi choice

- [ ] Anxiety
- [ ] Depression
- [ ] Bipolar disorder
- [ ] Schizophrenia
- [ ] Schizoaffective disorder
- [ ] PTSD
- [ ] Eating disorder
- [ ] Other

If "other" is checked, please specify

Approximate date

Approximate date of most recent disgnosis (or year)

Treating clinic or facility

Family history *

Family history of psychosis, bipolar disorder, or other major psychiatric conditions?

Family history of psychosis, bipolar disorder, or other major psychiatric conditions? Yes / No If Yes please describe

Hospitalization or emergency care *

History of psychiatric hospitalization or emergency care? Yes / No If Yes, dates and reasons:

Self Harm or suicidal thoughts *

Yes / No If Yes, current status and brief context:

Prior psychedelic and ketamine experiences (past)

Previous use of ketamine *

Yes / No If Yes, approximate age at first use

Typical settings

Usage dose range and route

Number of experiences to date

Adverse experiences

Give a detailed example

Any adverse experiences (panic, dissociation, distress, physical reactions)? Yes / No If Yes, brief details:

Current use and plans *

Are you currently using ketamine or planning unsupervised use outside a supervised setting? Yes / No If Yes, frequency and substances:

Spiritual/Transformative experiences (past)

Previous significant experiences *

Have you had significant transformative or spiritual experiences with ketamine or other psychedelics? Yes / No If Yes, describe: setting, context, insights, and integration outcomes:

Impact

How have these experiences impacted your beliefs, values, or sense of meaning?

Challenges and integration

Have you faced challenges with integration or distress after experiences? Yes / No If Yes, describe:

Supports

What supports helped with integration (therapy, community, journaling, meditation, etc.)?

Planned ketamine journey and goals

Planned journey and goals *

Primary goals for the journey (brief):

Safety planning and emergency readiness

Trusted person *

Do you have a trusted sober person available during and after the journey? Yes / No If Yes, name and contact information:

Medical emergency *

Do you have a medical emergency plan (clinic, hospital, emergency services)? Yes / No If Yes, details:

Current provider contact *

Are you currently under care for mental health or medical conditions? Yes / No If Yes, provider and contact:

Consent and Privacy

- [ ] I understand this form collects sensitive information for safety screening and care planning. If you understand, please check the box. If you do not understand, leave the box unchecked. *
- [ ] I understand this questionnaire is not a substitute for medical or legal advice. If you understand, please check the box. If you do not understand, please leave the box unchecked. *
- [ ] I have read both the Groking Wholeness **disclaimer** and **privacy** statements and agree to their terms (links to these statements are on the bottom of every Groking Wholeness web page) *

By typing my name below in the box labeled "signature", I electronically sign this document and affirm it has the same effect as my handwritten signature under applicable law.

Signature *

Printed name *

Date signed *

Month | Day | Year

Submit

email: info@GrokingWholeness.info